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Act (PDSA) testing we created a standardized ADL process that involved all providers. Interventions included addressing 1-2-3 compliance during rounds, creating accountability in care delivery, creation of an algorithm and order set for oral care, daily text message reminders, and physician intervention with non-compliant and high-risk patients.

Findings & Interpretation: Our baseline compliance with the 1-2-3 initiative was 25%. With our interventions we increased our median compliance to 66% in 90 days. The greatest impact on compliance was seen with text message reminders to staff to complete the 1-2-3 components, designated roles and responsibilities, and physician discussion with noncompliant and high-risk patients.

Discussion & Implications: Oral care algorithm and order set, daily text message reminders, and physician intervention with non-compliant and high-risk patients could all be adaptive to other units. Units where compliance with ADL participation is low would be an ideal environment to incorporate the ADL 1-2-3 initiative.

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Rounding with Purpose: Improving Communication, Safety and Collaboration with Nurse Driven, Multidisciplinary Family Rounds

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Topic Significance & Study Purpose/Background/Rationale: With an emphasis on patient safety, hospitals are utilizing practice models that incorporate highly reliable (HRO) practices to decrease the potential for human error (Seago, 2008). Additionally, ineffective communication and communication failures are the most commonly cited causes for sentinel events and approximately 50% of adverse events in the United States (JCAHO, 2008). In response to these patient safety concerns, communication during bedside patient rounds was examined on an in-patient Midwestern pediatric bone marrow transplant (BMT) unit. Improving the communication and collaboration within the multi-disciplined patient care team was addressed with the development and implementation of an HRO modeled report sheet, process and nurse lead bedside rounds.

Methods, Intervention, & Analysis: The primary intervention used HRO principles to increase effective collaborative communication by incorporating bedside nursing presence, nursing participation and advocacy, patient/family presence, patient/family participation in bedside rounds, and the implementation of a standardized report sheet.

Findings & Interpretation: BMT nurses were looking for a way to address patient care concerns and increase collaboration during the bedside rounding process. Pre-intervention data was gathered to assess the frequency of bedside nurse presence and participation during patient rounds at 37.5%. A standardized report sheet was developed by BMT nurses and physicians to address patient status, family concerns, and significant findings related to patient prevention standards, JCAHO and CMS compliance. Education was completed by all members of the multi-disciplined team. Post-intervention data collection via daily charge nurse audits is ongoing at 68% measuring nursing presence, participation and use of standardized report sheet.

Discussion & Implications: BMT multi-disciplined teams are using this intervention to address ongoing collaborative communication needs in the complex care of pediatric BMT patients. Utilizing this tool assists in effective communication, forming a culture of safety and reliability using a standard HRO modeled report process, and addresses JCAHO and CMS compliance.

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Identifying the Need for a Regional Nurse–Led Allogeneic Haematopoietic Stem Cell Transplant (allo-HSCT) Late Effects Follow Up Program

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Topic Significance & Study Purpose/Background/Rationale: Advances in allo-HSCT technologies have improved survival in patients. Wingard (2011) identified allo-HSCT recipients alive at 2 years post allo-HSCT had an 80-92% survival at 10 years. As a result patients experience chronic and late complications of transplant requiring lifelong surveillance (Gifford 2013). Calvary Mater Newcastle (CMN) refers 15-20 patients per annum for allo-HSCT. The increasing numbers of survivors >2 years post allo-HSCT are not able to be accommodated in the standard allo-HSCT follow up clinics. A need was identified to provide a model of care for long term survivors of allo-HSCT. A nurse-led approach was seen as a potential solution, a model supported by a steady growth in literature (Gates 2009).

Methods, Intervention, & Analysis: Clinics were established and coordinated by the BMT nurse coordinator, assisted by a hematology fellow and conducted parallel to the standard BMT clinic. Eligible patients were: more than 2 years post allo-HSCT, with no ongoing graft versus host disease (GvHD), in remission and requiring annual follow up. Patients were required to complete certain tests & screens prior to their appointment in accordance with recognized long term follow up (LTFU) guidelines. The survivorship care plan (SCP) specifically designed to address long term health issues in post allo-HSCT patients of the major center where patients are referred for allo-HSCT (Westmead Hospital) was used. Patients were provided with a copy of their SCP.

Findings & Interpretation: 60 patients were eligible to attend the clinic. The SCP provided an excellent framework for education, screening, prevention, improving coordinated care & communication. Greater nurse involvement in the clinic was identified as a key factor in improving continuity and patient centered care. However, trying to coordinate the LTFU clinics alongside the standard BMT clinic was found to be not feasible, due to staffing constraints. Therefore, planning is now proceeding to make the LTFU clinic run independent of the standard BMT clinic and be nurse-led.

Discussion & Implications: In Australia nurse-led follow up in allo-HSCT is emerging (Gates 2009). The benefits of a localized nurse-led late effects program ensure patient compliance with ongoing health surveillance and overall better patient outcomes by reducing patient travel for similar follow up in metropolitan centers.

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Withdrawn

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Sustaining a Standardized Cardiac Monitor Care Process to Reduce Nuisance Alarms

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